APPLICATION F OR CHILDREN'S MEDICAL BENEFITS

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

This application is only for persons under the age of 19 who want Medical benefits.

If you have any questions or need help with this form please call 1-800-562-3022 (TTY/TDD only 1-800-848-5429). Complete and mail to the Department of Social and Health Services (DSHS), Medical Eligibility Determination Services:

DSHS, MEDS
PO BOX 45531
OLYMPIA WA 98504-5531

Adults in the family who would like to apply for food stamps, medical benefits, or a cash grant need to call their local CSO for an Application for Benefits, DSHS 14-001(X). To find your CSO's telephone number, look in the blue (government) pages of your phone book under Washington State, Community Services Office (CSO).

As you fill out this application, you will see an icon that looks like this:

Doubleclick on it to view a "helpful hint" about how to answer that question.

(To close the hint, just click on the "dash" in the upper left-hand corner of the box.)

More hints:

1. After you are done with a question, hit "Tab" to move to the next item.
2. For drop-down menus, find the item you want and CLICK on it with the mouse.
   (If you don't click on it, your selection won't show up on the form.)

Health Care for Kids. . .

at no cost to you.

Here's How to Apply!

Here is a checklist to help you fill out your application:

Family income: Any income your household receives. Use information on:

- Recent pay stubs showing your income.
- Letter from your employer stating your GROSS wages (before taxes are taken out.
- Court custody agreement if you're getting child support.
- Self-employment records for the last 30 days.
- Award letters for benefits (some examples: Veterans Administration, Labor & Industries, Unemployment, Social Security).

Social Security numbers for all persons under the age of nineteen

AND

Complete names and birth dates of children to be covered

If you are uncertain of what's needed to confirm your income or if you have any other questions, please call our toll free line 1-800-562-3022 (TDD/Hearing Impaired ONLY 1-800-848-5429

Please mail your completed application to: DSHS, MEDS, PO BOX 45531, OLYMPIA WA 98504-5531

APPLICATION FOR CHILDREN'S MEDICAL BENEFITS

Washington State Department of Social & Health Services

Please read the following before completing the application.

This application is a statement of facts about the children who need medical care. You will need to answer all questions before we will know if we can help you. Please print.

Organization assisting client with application: _____

1. First Name | Middle Initial | Last Name

2. Address Where You Live | Street | City | State (WA) | Zip Code

3. Mailing Address (if different) | Street | City | State (WA) | Zip Code

4. Telephone Numbers
Home
Work
Message

5. Yes ☐ No ☐
Do you have trouble speaking, reading or writing English? . . . . . .
Do you need an interpreter? (If yes, we will communicate through an interpreter.) . . .
What language do you speak? Other:

6. Check the following boxes that apply to a person under age 19 in your household:
Pregnant Yes ☐ No ☐ Person under 19 has a medical condition which needs attention right away. Yes ☐ No ☐

General Information

7. List family members living together.

NAME (FIRST, MIDDLE, LAST)	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	APPLYING FOR BENEFITS? YES NO	*U.S. CITIZEN YES NO	SOCIAL SECURITY NUMBER	SEX M or F
A. Parent or Guardian	SELF					
B. Parent or Guardian						
C. List Persons Under 19 Years of Age			☐ ☐	☐ ☐		
D.			☐ ☐	☐ ☐		
E.			☐ ☐	☐ ☐		
F. List Others in Household			☐ ☐	☐ ☐		
G.			☐ ☐	☐ ☐		
*If you are not a U.S. citizen, complete Page 4 - Immigration Status			☐ ☐	☐ ☐		

8. A person under 19 years old in my household is disabled: Yes ☐ No ☐ If Yes, who?

Expenses

9. Do you pay someone to take care of your child(ren) or take care of a dependent adult while you work? Yes ☐ No ☐ If yes, how much per month?

10. Do you pay child support for a child who is not in your home? Yes ☐ No ☐ If yes, how much per month?

Enter GROSS pay, not take home pay. Enter zero ("0") if you or your spouse are not employed.

Income

Your Income From Employment	Spouse's Income From Employment (if you are married)
11. Employer Name and Phone Number	13. Employer Name and Phone Number
12. Amount you earn each pay period before taxes: $ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each week	14. Amount you earn each pay period before taxes: $ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each week

Other Income	Amount	How Often Do You Get This Income?	Which Family Member Gets This Income?
15. Child Support	$		
16. Alimony	$		
17. Social Security payment	$		
18. Unemployment benefits	$		
19. Interest from bank account	$		
20. Veterans benefits	$		
21. Labor and Industries	$		
22. Military Allotments	$		
23. Other (Please explain)	$		

Medical Information

24. Does the child you are applying for already have health insurance?
Yes ☐ No ☐

25. Have you had job related health insurance in the last 4 months?
Yes ☐ No ☐

If you checked "Yes" list the name of your insurance company or employer, the policy number and the policy holder's name and social security number.

Insurance Company or Employer	Policy Number	Policy Holder's Name	Policy Holder's SSN

26. Did any of your children living with you receive medical services in the past 3 months? Yes ☐ No ☐

Voluntary Information

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ Caucasian ☐ Hispanic ☐ Black ☐ Native American/Alaskan Native ☐ Vietnamese/Laotian/Cambodian

☐ Other Asian or Pacific Islander ☐ Other

Read Carefully Before Signing

I UNDERSTAND THAT:

- I must report immediately to the Department of Social and Health Services (DSHS), in writing or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof I am eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.
- DSHS may share your child's immunization history with the Department of Health's Child Profile Immunization Tracking System for purposes directly connected to the administration of medical programs
- **I understand this application is for medical benefits for children only. If my family needs financial assistance or food stamps, we must apply through a DSHS Community Services Office.**

Declaration and Signature(s)

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of Applicant	Date	Signature of Applicant	Date

Now that you are done, please:

1. Make sure you completed every item
   (If you checked "No" for a non-citizen child in Question 7, be sure you complete page 6 of this form.)
2. Sign the application; AND
3. Mail it to:

MEDS
PO BOX 45531
OLYMPIA, WA 98504-5531

ATTACHMENT A

IMMIGRATION STATUS

Please complete this section for any person applying for medical benefits who is not a United States citizen except for foreign students and tourists. If you have legal immigration status, attach copies of both sides of the document. You do not have to provide proof of immigration status for the family members who are not applying for benefits.

Name of person applying for medical care		Are you a United States citizen?		If not a United States citizen		
				Were you given a document showing your status?		If yes, list date you arrived in the United States
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
First	Last	YES ☐	NO ☐	YES ☐	NO ☐	
Signature						Date

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from the programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.